ARTICLE 5. CLASSIFICATION AND SEGREGATION

Section 1350. Admittance Procedures.

The facility administrator shall develop written policies and procedures for admittance of minors. In addition to the requirements of Sections 1324 and 1430 of these regulations:

(a) juvenile halls shall assure that a minor shall be allowed access to a telephone, in accordance with the provisions of Welfare and Institution Code Section 627; and,

(b) juvenile camps shall include policies and procedures that advise the minor of the estimated length of stay, and shall develop program guidelines that include written screening criteria for inclusion and exclusion from the program.

Guideline: The statutory authority to hold the minor must be determines upon admittance to the juvenile hall [i.e., **Welfare and Institutions Code Sections (WIC) 601/602** or other authorized contract, such one with the Immigration and Naturalization Services] WIC **Section 627** requires that a minor be advised and have the right to make two telephone calls, at public expense, within one hour after being taken into custody. One call must be completed to his/her parent or guardian, a responsible relative, or employer and the second call to an attorney.

The initial phase of confinement is critical to a minor. A full orientation, as required in **Section 1353, Orientation,** is important in easing the transition into the custody setting. **Intake health screening, Section 1430**, must occur at this time to assure initial medical/mental health clearance or to identify concerns needing further attention. Facility procedures should consider the need for a confidential setting when collecting sensitive personal information.

Title 24, Section 460A.1.1, Reception/Intake Admission, requires that, upon admittance, a minor must have access to a shower and a telephone. There must also be a secure vault or storage space for the minor's valuables. **Section 460A.1.19** addresses the secure storage requirements for a minor's personal clothing and belongings.

Section 1351. Release Procedures.

The facility administrator shall develop written policies and procedures for release of minors from custody which provide for:

(a) verification of identity/release papers;

(b) return of personal clothing and valuables;

(c) notification to the minor's parents or guardian;

(d) notification to the facility medical provider in accordance with Section 1437 of these regulations, for coordination with outside agencies; and,

(e) notification of school staff.

The facility administrator shall develop and implement written policies and procedures for the furlough of minors from custody.

Guideline: There is a need to properly identify the individual being released and return personal property. There must also be procedures to notify parents or a guardian as well as health care services and school staff. It is important this same process is followed when transferring a minor to another facility, to placement, or to a state institution. Timely notifications minimize security concerns.

Releases from a facility for the purpose of furlough will follow the above guidelines for release, and will include provisions for conditional release and return if required.

Section 1352. Classification.

The facility administrator shall develop written policies and procedures on classification of minors for the purpose of determining housing placement in the facility.

Such procedures shall:

(a) provide for the safety of the minor, other minors, facility staff, and the public by placing minors in the appropriate, least restrictive housing and program settings. Housing assignments shall consider the need for single, double or dormitory assignment or location within the dormitory;

(b) consider facility populations and physical design of the facility;

(c) provide that a minor shall be classified upon admittance to the facility; classification factors shall include, but not be limited to: age, maturity, sophistication, emotional stability, program needs, legal status, public safety considerations, medical/mental health considerations and sex of the minor; and,

(d) provide for periodic classification reviews, including provisions that consider the level of supervision and the minor's behavior while in custody.

Guideline: Classification is to ensure the appropriate housing and programming of minors, maintain the security of the facility and provide for the safety of staff and residents. It is not a tool for punishment or discipline. A preliminary classification should be done at the time of admittance. The initial classification focus is the health and safety of the minor, the safety of staff and the security of the facility.

A more complete classification should be completed as soon as possible. The overall classification system must take into account objective information obtained at the admission

screening, plus input from other sources such as: the juvenile; existing records; parents; victims; police; etc. Periodic reviews provide for needed flexibility and sensitivity to changing circumstances. Written documentation of the classification process aids in the coordination of minors' detention programs and consistent application of the classification system.

A facility's classification plan should consider at a minimum:

1. the physical layout of the facility;
2. the different security levels available in the facility;
3. the programs available;
4. the criteria used for classification and the minors legal status;
5. the appeal process for both staff and minors;
6. the time frames for periodic review of the classification;
7. personnel issues such as who makes classification decisions and the lines of communication for classification information;
8. maturity and sophistication of minors within the facility; and,
9. the types of available housing (single/double occupancy rooms) and the locations and sizes of dormitories.

Classification systems are important in all detention settings, camps as well as juvenile halls. The classification system should address the safety of minors in various types of housing; from single/double occupancy rooms large dormitories.

There are several approaches to managing classification. Some facilities use formal input from probation, medical, mental health and other program staff. Others utilize only information from custody staff. Staff training in the implementation of the classification plan is essential. The facility administrator should distinguish the unique differences between juvenile halls and camps when establishing a classification system.

The classification plan should be readily available in the minor's record on the living unit and be accessible to all staff. It will assist staff in appropriately assessing the group dynamics. Written records of any subsequent review and modifications should also be included in the minor's file. Requests by minors for "quiet time" and short term "time outs" for behavior control and any other removals from regular program and group activities should also be documented in the minor's file in addition to the unit log.

Section 1353. Orientation.

The facility administrator shall develop written policies and procedures to orient a minor prior to placement in a living area. Both written and verbal information shall be provided. Provision shall be made to provide information to minors who are impaired, illiterate or do not speak English. Orientation shall include:

(a) facility rules and disciplinary procedures;

(b) grievance procedures;

(c) access to legal services;

(d) access to health care services;

(e) housing assignments;

(f) availability of personal care items and opportunity for personal hygiene;

(g) correspondence, visiting and telephone use;

(h) availability of reading materials, programs, and activities;

(i) use of restraints and chemical agents;

(j) use of force; and,

(k) emergency and evacuation procedures.

Guideline: It is important for staff to recognize that minors who are newly received in the facility are often in crisis. They may be under the influence of various substances, frightened or disoriented. They are concerned about personal and family problems and worried about the custody environment; they also may be unable to express these concerns. Staff may be able to reduce tension, ease the transition to detention and facilitate managing the minors by taking time to listen and respond to individual concerns and needs during orientation.

If minors are to be held accountable for following the rules and exercising their rights and privileges, then facility personnel have an obligation to inform the minors of those rules, rights and privileges before problems can develop. Orientation provides minors with information about facility procedures, rules, behavior expectation, services, and activities that they must be familiar to function successfully. When is visiting? How do I get to see a doctor? These and similar questions should be answered by orientation. Orientation is intended to reduce rule violations and decrease staff time spent answering basic questions.

Some facilities use videotape presentations to orient minors. Video orientations may be shown in the receiving area or housing unit. These kinds of orientations can be available in the language or languages most commonly used by minors in the specific facility. A well-done orientation video has the advantage of freeing staff from having to repeat the same information over and over and being consistent and uniform so that everyone gets the necessary information the same way.

Handbooks or handouts are useful for orientation, but written material must be supplemented by discussion of the material with staff. It may be necessary to assess the minor's understanding of the rules. Simply giving the minor a written document does not guarantee that he/she will read or understand the information. If the goal is to familiarize minors with the operation of the facility,

there must be some verbal or visual explanation of the handbook. The minor must be encouraged to read the material. If a minor is unable to read or is unable to read English, then the information must be presented verbally or written in a language that the minor is able to understand.

Section 1354. Segregation.

The facility administrator shall develop written policies and procedures concerning the need to segregate minors. Minors who are segregated shall not be denied normal privileges available at the facility, except when necessary to accomplish the objectives of segregation. Written procedures shall be developed which provide a review of all minors to determine whether it is appropriate for them to remain in segregation and for direct visual monitoring. When segregation is for the purpose of discipline, Title 15, Section 1390 shall apply.

Guideline: Segregation is an option afforded to facility administrators to maintain order, safety, and security. The facility administrator controls segregation and it must not be used in an arbitrary manner. There is a need for some degree of "due process" that includes communication with the minor and providing him/her with the opportunity to voice complaints. Allowing the minor to tell his/her "side of the story" is necessary. This may be as simple as an interview with the minor to advise him/her of the placement and the opportunity to respond to the information. Segregation is also subject to the grievance process discussed in **Section 1361, Grievance Procedure**. The facility administrator and/or classification committee must regularly review the minor's status to confirm whether the segregation continues to be necessary.

Segregation may include restricting privileges. These restrictions should correspond to the need for segregation, the limitations of the facility and the reasons for placement in segregation. Situations should not be allowed to develop whereby there is no fundamental difference between routine segregation and disciplinary housing.

When segregation is used as pre-disciplinary housing pending a disciplinary hearing, that decision must be based on the need to segregate rather than an attempt to limit privileges pending a hearing. This means that the minor's conduct was serious enough that it was unsafe or inappropriate for him/her to remain in general housing. Only those restrictions necessary to maintain the safety, security, and order of the facility pending disciplinary procedures should be utilized **(Section 1391, Discipline Process)**.

Segregation is often used to accomplish protective custody; either when the minor requests it or the administration determines there is reason to believe it is warranted. Minors sometimes request segregation for their own protection, generally because they feel threatened. It is important to document the reasons for placement in segregation, as well as the reasons for denying a minor’s request. This segregation should be for the least amount of time necessary to reintegrate the minor back into the general population. Segregation separates the minor from the general population, and staff should be especially attentive to signs of depression and/or suicide risk.

In the development of segregation policies and procedures, the facility administrator must consider the conditions for segregating status offenders from minors as described in **WIC, Section 602,** and must assure compliance with **WIC Section 207.**

Section 1355. Assessment and Plan.

The facility administrator shall develop written policies and procedures to provide that for post-adjudicated minors held for 30 days or more, an assessment and plan shall be developed within 30 days of admission. The assessment and plan shall be documented.

(a) The assessment is a statement of the minor's problems, including, but not limited to, identification of substance abuse history, educational, vocational, counseling and family reunification needs.

(b) The plan shall include, but not be limited to, written documentation that provides:

- **(1) objectives and time frames for the resolution of problems identified in the assessment;**
- **(2) a plan for meeting the objectives that includes a description of program resources needed and individuals responsible for assuring that the plan is implemented;**
- **(3) periodic evaluation or progress towards meeting the objectives, including periodic review and discussion of the plan with the minor;**
- **(4) a transition or aftercare plan, subject to existing resources, that is completed prior to the minor being released; and,**
- **(5) contact with the Regional Center for the Developmentally Disabled for minors that are developmentally disabled, including provisions of Section 1413(b).**

Guideline: Within 30 days of admission, a complete assessment and plan must be prepared for any post-adjudicated minor held in the facility for a period of 30 days or more. This includes minors housed in juvenile hall while awaiting transfer to camp, placement or elsewhere. The assessment and plan requires staff to begin assessing the needs of those minors and addressing those needs as soon as possible. There must be a periodic review of progress toward meeting the plan's objectives as well as planning for transition to aftercare status upon release. Probation departments are also encouraged to connect the assessment and plan to services the minor will receive upon release from the facility and/or program.

The facility administrator, along with the health authority, should develop policies which assure that anyone with suspected developmental disabilities is segregated when the person's behavior indicates that his or her safety would be jeopardized in general population. Although not all of those with developmental disabilities require segregation, minors with developmental disabilities are often highly susceptible to assaults and abuse. The facility's screening and classification systems **(Section 1352, Classification)** must identify individuals with developmental disabilities and house them appropriately.

Many juvenile facilities do not have medical staff with specific training in diagnosing developmental disabilities. Regional Centers for the Developmentally Disabled are to be notified within 24 hours, excluding weekends and holidays, so appropriately trained staff will be able to make the diagnosis and determine eligibility for services (Regional Center information may be accessed via the Internet at **www.dds.ca.gov/regctrs/main/rclist.cfm)**. If it is not possible to meet the 24-hour deadline, then a phone call and a follow-up letter to the regional center should be done as soon as possible advising the center that you have a developmentally disabled minor in custody. However, a regional center is under no obligation to respond to referrals from the facility.

If not already on the regional center caseload, a developmentally disabled minor must meet the criteria for admission **(Section 1302, Definitions)**. If the regional center does not accept a minor, there is an appeal process through the Client's Rights Office of each center through which custody or health care staff can initiate on the minor's behalf.

Facilities should develop ongoing working relationships with their local regional center and provide in-service training for correctional and health care staff on developmental disabilities. This would be helpful to the minor and assist the facility's operators.

Section 1356. Counseling and Casework Services.

The facility administrator shall develop written policies and procedures ensuring the availability of appropriate counseling and casework services for all minors. Policies and procedures shall ensure:

(a) minors will receive assistance with personal problems or needs that may arise;

(b) minors will receive assistance in requesting contact with parents, attorney, clergyman, probation officer, or other public official; and,

(c) minors will be provided services as appropriate to the population housed in the facility, and may include, but not be limited to: substance abuse, family crisis and reunification, counseling, public health and mental health services.

Guideline: Minors received in juvenile facilities generally bring many personal issues and problems with them from the community. This regulation is intended to ensure that staff provides counseling and casework to minors in their care. There is an expectation that child supervision staff is to provide such service to minors. Although child supervision staff is not expected to handle extensive health/mental health issues, they are able to provide emotional "first aid," and make appropriate referrals as needed. Minors can expect guidance in areas of family reunification, substance abuse counseling, behavior modification and many other areas that may assist a minor in successfully handling routine issues.

Section 1357. Use of Force.

The facility administrator, in cooperation with the responsible physician, shall develop written policies and procedures for the use of force, which may include chemical agents. Force shall never be applied as punishment, discipline or treatment.

(a) At a minimum, each facility shall develop policy statements which:

- **(1) define the term "force," and address the escalation and appropriate level of force, while emphasizing the need to avoid the use of force whenever possible and using only the amount of force necessary to ensure the safety of minors and others;**
- **(2) describe the requirements for staff to report the use of force, and to take affirmative action to stop the inappropriate use of force;**
- **(3) define the role and notification of medical and mental health staff concerning the use of force; and,**
- **(4) define the training which shall be provided and required for the use of force, including the training on use of less than lethal force.**

(b) Policies and procedures shall be developed which include, but are not limited to, the types, levels and application of force, documentation of the use of force, a grievance procedure, a system for investigation of the use of force, and discipline for the improper use of force. Such procedures shall address:

- **(1) the specific use of physical, chemical agent, lethal, and non-lethal force that may, or may not, be used in the facility; and,**
- **(2) a standardized format, time period, and procedure for reporting the use of force, including the reporting requirements of management and line staff.**

Guideline: Use of force is an immediate means of overcoming resistance to control the threat of imminent harm to self or others. The use of force may occasionally be necessary for the safety of staff and minors in custody. It often brings with it the hazard of injury to staff and minors, as well as the potential for abuse and litigation. The application of force requires clear policy and procedures to provide staff with the necessary direction and parameters regarding when it is appropriate and that it should not be used as punishment. Use of force should only be used when less restrictive methods have failed. Written restrictions on the application of force and the procedures for application and follow-up are necessary.

Policy and procedures need to identify what is considered "use of force" and should describe the continuum of escalation that should be followed as closely as possible. Facilities may vary on definition of force and when different levels are appropriate. Policy and procedures should also discuss both the need to avoid the use of force and only using the amount of force necessary to ensure the safety of minors and staff. Strong verbal intervention may be considered a type of force or may be considered a prelude to force intervention. Chemical weapons such as pepper spray may be prohibited, or the highest level of escalation allowed prior to "hands-on" force. The facility administrator must establish a clear expectation regarding the use of force, while providing for a broad range of incidents that may or may not permit adherence to a rigid continuum of escalation. The facility purpose, available resources and the court's expectation should weigh into the development of this policy.

Use of force brings with it the anticipation of potential injury. Medical procedures and documentation require the specialized input of the responsible physician who can base restrictions and follow-up procedures on the availability and limits of medical resources as well as any needs resulting from the use of force. Follow-up can include mental health as well as physical assessments of both minor and staff. The lack of apparent injury does not necessarily mean that injury has not occurred.

Documenting incidents involving the use of force is critical for management evaluation and control. Timely submittal of a comprehensive and structured report allows management to access to the documentation and maintains the agency's credibility. Complete reports and log entries establish the credibility of the staff involved. Generally, reports on the use of force should be completed prior to the end of shift, and not later than 24 hours after the incident has occurred. Procedures regarding the routing and use of force reports should provide clear direction. Documentation of an incident does not take precedence over the immediate needs of an individual during or after an incident; however, staff should be sensitive that there is a degree of urgency to begin the report process as soon as possible. Provision should be made for the minor's statement to be incorporated into the documentation.

Management review should be timely and consider a range of issues including:

1. Were policies and procedures followed?
2. Did policies and procedures address the issues in this incident?
3. What is the minor's side of the incident?
4. Is the use of force a pattern that indicates a need for management action to avoid the need in the future?
5. Is the documentation and follow-up something that could be defended in litigation?
6. Are there any pending issues or injuries that require further follow-up?

The appropriate use of force requires training. This training includes a clear understanding of the facility policy and procedures that are employed before, during and after an incident. Staff should be knowledgeable about the authorization and limitations on the use of force, and should practice the techniques of application. Policy and procedures should also address training and steps taken to use chemical force, as well as a policy statement prohibiting lethal force.

Staff should also be trained to respond to incidents of "gassing" within the facility, and the use of force that may be needed to control that situation. For the purposes of this guideline, "gassing" means intentionally placing or throwing, or causing to be placed or thrown, upon the person of another, any mixture of human excrement or other bodily fluids or substances.

Section 1358. Use of Physical Restraints.

(a) The facility administrator, in cooperation with the responsible physician and mental health director, shall develop written policies and procedures for the use of restraint devices. In addition to the areas specifically outlined in this regulation, as a minimum,

the policy shall address the following areas: known medical conditions that would contraindicate certain restraint devices and/or techniques; acceptable restraint devices; signs or symptoms which should result in immediate medical/mental health referral; availability of cardiopulmonary resuscitation equipment; protective housing of restrained minors; provision for hydration and sanitation needs; and exercising of extremities.

(b) Restraint devices include any devices which immobilize a minor's extremities and/or prevent the minor from being ambulatory. Physical restraints should be utilized only when it appears less restrictive alternatives would be ineffective in controlling the disordered behavior. Physical restraints shall be used only for those minors who present an immediate danger to themselves or others, who exhibit behavior which results in the destruction of property, or reveals the intent to cause self-inflicted physical harm.

(c) Minors shall be placed in restraints only with the approval of the facility manager or the shift supervisor. The facility manager may delegate authority to place a minor in restraints to a physician. Continued retention in restraints shall be reviewed a minimum of every hour. A medical opinion on the safety of placement and retention shall be secured as soon as possible, but no later than two hours from the time of placement. The minor shall be medically cleared for continued retention at least every three hours thereafter. A mental health consultation shall be secured as soon as possible, but in no case longer than four hours from the time of placement, to assess the need for mental health treatment.

(d) Continuous direct visual supervision shall be conducted to ensure that the restraints are properly employed, and to ensure the safety and well-being of the minor. Such observation shall be documented. While in restraint devices all minors shall be housed alone or in a specified housing area for restrained minors which makes provision to protect the minor from abuse. In no case shall restraints be used as punishment or discipline, or as a substitute for treatment. Additionally, the affixing of hands and feet together behind the back (hogtying) is prohibited.

(e) The provisions of this section do not apply to the use of handcuffs, shackles or other restraint devices when used to restrain minors for movement or transportation reasons.

Guideline: The use of restraints is a complex issue, fraught with the possibility of liability and lending itself to the potential for injury to minors. Restraints are to be applied only on those minors who present an immediate danger to themselves or others, who exhibit behavior that results in the destruction of property or reveals an intent to cause physical harm to self or others. The use of physical restraints cannot be considered if known medical conditions would place the minor at risk when used. Restraints are not for use as punishment and are applied only when less restrictive ways of controlling a minor's dangerous behavior have failed or appear likely to fail.

There is a distinction between the "use of force" and the use of restraints. "Use of force" is an immediate means of overcoming resistance to control the threat of imminent harm to self or

others. The use of restraints is a more sustained, prolonged intervention. It is sometimes difficult to determine when use of force ends and application of restraints begins. Force is a custody/law enforcement function. Application of restraints for prolonged periods of time requires greater emphasis on medical concerns and involvement of medical staff. This differentiation is based on the understanding that aggressive behavior that is not the result of underlying medical or mental health causes can be dealt with swiftly and definitively by custody staff. These minors will reach a decision point where their behavior comes under control relatively quickly. More prolonged behavior disturbances may be symptomatic of underlying psychological or medical problems requiring specific intervention and monitoring. This regulation relates to restraint that is typically prolonged and applied because control over the minor's behavior cannot be maintained through less restrictive means. Shackles and handcuffs are generally used as security restraints or in conjunction with use of force; they should be avoided as long term restraint devices in favor of devices designed for safer use over more prolonged periods of time.

This standard does not address use of force policy **(Section 1357, Use of Force)**. It specifically states that it does not apply to force used for security reasons. This is not to suggest that there are no liability and injury concerns related to the "use of force." Custodial staff frequently must temporarily restrain a minor to gain control of a situation. Many of the medical concerns related to the prolonged use of restraints can also apply to the shorter-term use for security and gaining immediate control. Facility administrators should regularly review the use of restraints and the use of force policies to assure that policies are followed and restraint equipment is properly utilized and controlled.

There are medications that serve as chemical restraints to control behavior **(Section 1439, Psychotropic Medications)**. These can only be prescribed and administered by licensed medical staff. There are also environmental restraints such as the rooms identified in **Section 1359, Safety Room Procedures.** This regulation speaks specifically to physical restraints. Physical restraints are devices that immobilize a minor's extremities or limit physical mobility. Examples include soft ties, padded belts and cuffs, metal hand and ankle cuffs and restraining chairs or boards. Only restraints specifically manufactured for the purpose of restraining such persons safely should be used. Restraints should not be confused with postural supports, which may be required for other medical reasons, and neither should this regulation be interpreted to impose a restriction on the use of handcuffs, shackles or other devices to restrain minors for security or transportation purposes. Appropriately meeting the intent of this regulation is determined by the purpose and under what circumstance restraint devices are applied. This criterion is a more significant factor than the kind of device or equipment used.

Excluding short-term use of force to gain immediate control, placing a minor in restraints requires management approval prior to taking action. Approval for putting a minor in restraints must come from the facility manager or shift supervisor. If the facility manager has explicitly delegated that authority, a physician may also have the authority to place a minor in restraints. If delegated to a physician, the language does not preclude the facility manager from making the decision to place a minor in restraints. Medical assessment and input is required for continuing the use.

The facility administrator, in conjunction with the responsible physician, must develop policies and procedures for the appropriate use of restraint devices. The responsible physician must be involved in creating the policy and procedures because use of physical restraints carries numerous medical and mental health risks that require close monitoring. A partial list of these risks includes: neurological or muscular injury; circulatory impairment; dehydration; exhaustion, especially as it relates to the dangers of struggling; respiratory and cardiac collapse; fractures; kidney damage; strangulation; aspiration, especially if a minor is restrained on his or her back; failure to diagnose a serious underlying medical condition; and the possibility of exacerbating the mental condition. Policies must be consistent with both medical and custody considerations and reflect the actual operation of the facility. Both a facility's **Policy and Procedures Manual (Section 1324)** and the **Health Care Procedures Manual (Section 1409)** should address the appropriate use of restraint devices.

Policy and procedures should address exercising the extremities of minors in restraints. Rather than specify what are medically known as "range of motion" procedures in the regulation, the intent here is for the facility manager and responsible physician to develop procedures that fit with the types of restraints used in the particular facility or system. Procedures, practices and staff training should outline the range of motion procedures in detail as they relate to specific restraints and circumstances. Current federal mental health regulations require range of motion exercise of alternating extremities a minimum of ten (10) minutes every two hours. Arguably, extremity exercise policies may vary for sedate versus "struggling" minors.

Local policy and procedures must identify signs and symptoms that would result in an immediate medical/mental health referral. Again, the responsible physician must be instrumental in developing these, as medical and mental health backgrounds are necessary to identify the range of behaviors and signs that a minor has a significant medical or mental health problem. Some of the conditions which may prompt use of restraints or result from use of restraints are potentially life threatening and must be dealt with by properly trained medical/mental health personnel as soon as they are identified.

Minors in restraints must be provided the necessary food and fluids, and provision must be made to accommodate toilet needs of minors in restraints. Each facility with minors in restraints must have access to policy and procedures addressing the availability of cardiopulmonary resuscitation equipment. The facility's emergency evacuation plan must consider the special needs of minors who lack mobility due to the restraints.

There are six (6) kinds of checks, which must be performed whenever a minor is held in restraints. First, every minor in restraints must be under continuous direct visual supervision. **Section 1302, Definitions,** defines this as staff being constantly in the presence of the minor. The use of physical restraints increases the risks to a minor's physical extremities. The potential for injury to the minor creates the need for constant staff observation.

Second, minors in restraints must be reviewed for continued retention a minimum of once every hour. This hourly time frame is a decision-making point. The specific determination to continue a minor in restraints is left to the facility manager or designated physician. Delegation of the

authority to conduct the hourly review must be a custody or medical supervisor designated to perform the function.

Third, as soon as possible, but within two (2) hours of placement in restraints, the minor must have a medical assessment to determine whether he/she has a serious medical condition which is being manifested by the aggressive behavior. Some acting out behavior may be symptomatic of serious or life threatening illnesses. It is imperative that licensed medically trained staff examines the minor as soon as possible, but not more than two hours after being placed in restraints. Given the liability and medical ramifications of long-term restraints, minors should not be restrained in facilities that cannot accomplish a medical assessment by licensed medically trained staff within two hours.

Fourth, the minor must be medically cleared and approved for remaining in physical restraints. This clearance must take place every three (3) hours thereafter, to determine the appropriateness of continued use of the restraints.

Fifth, as soon as possible but within four (4) hours of placement in restraints, the minor must be evaluated by a licensed medical health professional to assess whether or not he/she needs immediate and/or long-term mental health treatment. While it is advisable for the mental health assessment to occur as soon as possible, not all facilities have mental health resources immediately available. Slightly more time is allowed for this evaluation because the minor has already been subjected to a medical evaluation and has had regular custody and medical reviews for retention.

Finally, while the minor must be in the constant presence of staff while in restraints (direct visual supervision), the actual times of the reviews and evaluations required by this regulation must be documented together with pertinent decisions and observations of the minor's behavior. Any actions taken should be noted in the log might be similar to the example provided for safety room monitoring. Logs should be monitored by the facility manager or other designated supervisor to assure entries are consistently and accurately recorded.

Included in this regulation is the need to protect restrained minors from abuse by other minors. Under no circumstances should restrained minors be housed with minors who are not in restraints.

Section 1359. Safety Room Procedures.

The facility administrator, in cooperation with the responsible physician, shall develop written policies and procedures governing the use of safety rooms, as described in Title 24, Part 2, Section 460A.1.13. The room shall be used to hold only those minors who present an immediate danger to themselves or others, who exhibit behavior which results in the destruction of property, or reveals the intent to cause self-inflicted physical harm. A safety room shall not be used for punishment or discipline, or as a substitute for treatment. Policies and procedures shall:

(a) include provisions for administration of necessary nutrition and fluids, access to a toilet, and suitable clothing to provide for privacy;

(b) provide for approval of the facility administrator, or designated shift supervisor, before a minor is placed into a safety room;

(c) provide for continuous direct visual supervision;

(d) provide that the minor shall be evaluated by the facility administrator, or designee, every four hours;

(e) provide for immediate medical assessment, where appropriate, or an assessment at the next daily sick call;

(f) provide that a minor shall be medically cleared for continued retention every 24 hours;

(g) provide that a mental health opinion is secured within 24 hours; and,

(h) provide a process for documenting the reason for placement, including attempts to use less restrictive means of control, observations of the minor during confinement, and decisions to continue and end placement.

Guideline: Title 24, Section 460A.1.13, describes the design, furnishings and equipment that are appropriate for safety rooms. **Title 24, Section 13-201(c) 2, Program Statement** and **Section 13-201(c) 3**, **Needs Assessment Study** identify administrations initial decisions regarding whether a facility will have safety rooms.

There is no requirement that a facility have a safety room. Facilities lacking a safety room must have clear policy and procedures for managing minors who present an immediate danger to themselves or others, who exhibit behavior that results in the destruction of property or reveal an intent to cause self-inflicted physical harm. The safety room is not to be used for "attitude adjustment," discipline, or punishment and it is not a substitute for treatment. The safety room is not a detoxification/sobering cell and is not to be used for that purpose. While it is preferable to transfer these minors to another facility, many mental health units are not equipped to handle people whose criminal behavior makes them a security concern. In these instances, the juvenile facility is often the last resort.

Safety rooms are a potential source of litigation and many other problems; therefore, their construction, operation and management must be carefully monitored. The purpose of this regulation is to control the use of the safety rooms and thereby avoid the extensive liability that occurs from using the room without the necessary safeguards. The facility administrator must work with the responsible physician to develop policy and procedures for the appropriate use of safety rooms, as there are medical and mental health ramifications related to their use. The facility **Policy and Procedures Manual (Section 1324)** and the **Health Care Procedures Manual (Section 1409)** must describe the appropriate use of these rooms and the roles of health care and probation staff.

Placing a minor in a safety room requires prior management approval. The only exception to prior approval is in the most volatile of circumstances. In this instance, staff may place the minor in a safety room while obtaining approval to keep the minor or others from being injured. Approval for the use of the safety room can come from the facility manager or the designated shift supervisor. Delegating safety room placement authority to a designee is permissive, and must be done by the facility manager. Policy must indicate who has this responsibility.

Every minor in a safety room must be provided continuous direct visual supervision **(Section 1302, Definitions)**. This means that staff is constantly in the presence of the minor and that audiovisual monitoring cannot substitute for the personal presence. The emphases on direct visual supervision ensures the safety of minors who are at risk of injuring themselves or are otherwise unstable.

Minors must be reviewed for continued retention in safety rooms at a minimum of every four (4) hours. The intent is that the facility manager or designated shift supervisor will conduct this review, whoever is designated by policy as having the placement authority. At this review, it must be determined whether the minor can be safely removed from the safety room. It is the intention of this regulation that minors should be removed from the safety room as soon as it is safe. No minor should be retained in a safety room longer than is necessary for the protection of the minor or others.

Immediately after placement in the safety room, but no later than the next daily sick call, each minor must have a medical assessment to determine whether he/she has serious medical conditions which are being masked by the aggressive behavior. Some acting out behavior may be symptomatic of serious or life threatening illnesses. The minor must be medically cleared for retention every 24 hours thereafter. Additionally, a mental health evaluation must occur within 24 hours of placement in the safety room to determine the minor's need for mental health services and suitability for retention in the safety room.

While the minor is in the safety room and under the continuous direct visual supervision of staff, all checks and reviews must be documented with actual time recorded along with any pertinent observations of the minor's behavior. Any actions taken should be noted on the log. The log should be monitored by the facility manager or other designated supervisor to assure entries are consistently and accurately recorded.

Specific staff procedures must be established to accommodate the minor's needs for nutritional requirements and fluid intake. Fluids are especially important given that minors in safety rooms are likely to have high fluid replacement needs due to elevated physical exertion. Paper plates, cups and other non-hazardous materials lessen the risks in addressing the nutritional and fluid needs of safety room detainees. Because safety rooms are not required to have a toilet, staff procedures must address escorting the minor from the safety room to appropriate toilet facilities.

Section 1360. Searches.

The facility administrator shall develop written policies and procedures governing the search of minors, the facility, and visitors. Searches shall be conducted to ensure the safety and security of the facility, and to provide for the safety and security of the public, visitors, minors, and staff. Searches may be conducted as deemed necessary by the facility manager on a routine or random basis. Searches shall not be conducted for harassment or as a form of discipline or punishment. Body cavity searches, as defined in Penal Code Section 4030, shall be conducted by medical personnel. Written procedures shall address each of the following:

(a) intake searches which may include pat-downs, metal detector, and clothing searches. (Strip searches and visual body searches shall be conducted only with prior supervisory approval, and only upon reasonable suspicion that a minor is in possession of a weapon or contraband, as provided in Penal Code Section 4030; minors accused of felonies may, in addition to the preceding, be visually observed during the shower process by a staff member of the same sex as the minor);

(b) searching minors who are returning from court, or from another facility; when appropriate, the searches may include pat-down, metal detector, clothing, strip, and visual body cavity searches;

(c) facility searches that address procedures to search both minors and their personal property within the facility;

(d) limited administrative searches of visitors to ensure the safety, security, and sound operation of the facility; and,

(e) cross gender supervision shall distinguish between visual supervision, pat-down searches, and more intrusive searches, as well as the suspension of restrictive procedures during emergencies, in conformance with Penal Code Section 4030.

Guideline: Searches are necessary to ensure the safety and security of the facility and to provide for the safety and security of the public, visitors, minors, and staff. Searches are conducted to maintain an environment as free as possible from any material prohibited by policy and procedures.

The types of searches, pat down, strip search and visual body cavity search should be defined and the procedures to conduct such searches clearly described. Any body search, excluding pat down searches, should be conducted by staff of the same gender as the minor except in documented emergency circumstances. Only licensed medical staff can do an intrusive body search. Any opposite sex searches should be accomplished in the presence of another staff member. Procedures should be established for searches whenever a minor enters or leaves the facility, subsequent to visiting, and for routine institution security. Searches should not be conducted for harassment or as a form of discipline or punishment.

Each facility needs to consider the need for limited administrative searches of visitors to ensure the safety, security, and sound operation of the facility. A notice informing all visitors of the

visitor search policy should be posted in a conspicuous place at both entrance and departure points of the facility.

Case law has consistently held that strip searches can only be performed in strict compliance with the provisions and definitions set forth in **Penal Code Section 4030**. Improper search procedures can lead to costly litigation.

Section 1361. Grievance Procedure.

The facility administrator shall develop written policies and procedures whereby any minor may appeal and have resolved grievances relating to any condition of confinement, including but not limited to health care services, classification decisions, program participation, telephone, mail or visiting procedures, and food, clothing, or bedding. Policies and procedures shall include provisions whereby the facility manager ensures:

(a) a grievance form and instructions for registering a grievance, which includes provisions for the minor to have free access to the form and to deliver the form to any child care supervision staff working in the facility;

(b) resolution of the grievance at the lowest appropriate staff level;

(c) provision for a review and response to grievances within a specified time limit;
- **(1) The minor may elect to be present to explain his/her version of the grievance to a person not directly involved in the circumstances which led to the grievance.**
- **(2) Provision for a staff representative approved by the facility administrator to assist the minor.**

(d) provision for a written response to the grievance which includes the reasons for the decisions; and,

(a) a system which provides that any appeal of a grievance shall be heard by a person not directly involved in the circumstances which led to the grievance.

Whether or not associated with a grievance, concerns of parents, guardians, staff or other parties shall be addressed and documented in accordance with written policies and procedures within a specified timeframe.

Guideline: It is the responsibility of the facility administrator to assure that the grievance process is in place. This process begins with minors having free access to grievance forms. A good grievance procedure is straightforward and easy for staff and minors to use. It is valuable as a management tool because it can minimize writs and lawsuits against the facility. A good grievance procedure will assure that facility personnel listen to minors' concerns and remedy what needs correcting. This can prevent small problems from becoming big problems, and can prevent big problems from becoming lawsuits. It is appropriate that the facility manager or a designee monitor the grievance process to assure that it is operating as intended. Modifications should be made when necessary.

The grievance mechanism may also serve as a self-inspection system. Along with incident reports **(Section 1362)** and the disciplinary process **(Section 1391)**, grievances provide important information for facilities to use in either formal or informal internal audits. They can tell facility administrators what is working and what is not working. Grievances can be an open line of communication from minors to staff, and from staff to management for identifying and correcting deficiencies. Facility managers have an obligation to review grievances, along with incident and disciplinary reports, to get an overview of what is going on in the facility or system.

The grievance procedure can serve as documentation of good faith efforts to remedy difficulties and improve conditions of confinement that comply with accepted standards. In this regard, as well as for the auditing purposes mentioned above, it is helpful to retain grievances in a minor's file. Having a log or master file of grievances and their resolutions may help the facility administrator see trends and patterns as well as respond to lawsuits.

The policies and procedures for grievance review and resolution should include:

1. a discussion of staff training in the effective use of the grievance process and how to resolve matters at the lowest possible staff level;
2. the mechanisms by which minors are made aware of the grievance procedure (beginning with orientation) and how to set the process in motion;
3. acknowledgement that grievances must be handled judiciously and within the time limits set by the procedure; and,
4. provision for the minor to explain his/her version of the grievance and for staff to assist when needed.

The grievance mechanisms can diffuse potential problems. Conflicts that are described in writing can be more readily resolved and often with better results than personal confrontations. Grievances are to be resolved at the lowest appropriate level in the chain of command, with the intent of addressing issues in a timely manner. Supervisory staff should be aware of grievances as they arise and move to assist in the process if necessary. In some facilities, appeals go from line staff to first line supervisor to the facility administrator. In others, grievances are appealed from line staff to first line supervisor or shift supervisor. This regulation requires one level of appeal and review. Additional reviews and appeals may be needed in some systems and are based on management's prerogative. A facility administrator may develop policies and procedures that exceed this regulation.

This regulation requires that at each step of the process, a minor must receive written reasons for the action taken, including approvals as well as denials. The notification should be documented. Carbonless forms with the minor's and staff's signatures may be good ways to end two of the more frequently encountered complaints of minors (i.e., that staff destroyed a minor's grievance or that a minor was unaware of the grievance process). The grievance should continue to a resolution even though the minor has been released during the process. Minors deserve a response to their grievance and facility administrators should insist that the process is consistently applied.

Grievances occasionally raise the issue of jurisdictional/administrative differences. For example, there may be instances of conflict between medical and custody personnel. Since the facility administrator is the final authority on custodial and security issues and the responsible physician has the responsibility for medical decisions, there must be some established procedure for resolving jurisdictional/administrative disagreements.

This regulation also requires a mechanism in which complaints and concerns of parents, guardians, staff and other concerned parties be addressed. Policy and procedures must address documentation and written responses to these complaints and concerns.

Section 1362. Reporting of Incidents.

A written report of all incidents which result in physical harm, serious threat of physical harm, or death to an employee or a minor of a juvenile facility, or other person(s) shall be maintained. Such written record shall be prepared by the staff and submitted to the facility manager by the end of the shift.

Guideline: Incidents that result in physical harm or serious threat of physical harm to staff, minors or others require particular attention. The incident report logs and systems aid in the ability to investigate crimes or rule infractions. They are also valuable in defending the facility against lawsuits. Documentation provides substantive assistance to staff or facility administrators called to testify about an incident that may have occurred months or years earlier. This documentation serves as quantitative evidence of conditions in a facility and may indicate where staff needs additional specialized training or where procedures are not serving the purposes for which they were intended. The incident report must be submitted by the end of the reporting party's shift.

The policy and procedures relating to incident reports should include: a definition of "incident;" who is responsible for producing the report; what material must be included in the report; reporting timelines; and how the report is filed and processed. These reports must be legible and comprehensible and include "who, what, when, where," as well as any corrective action taken. Incident reports by their nature integrate with other policies and procedures (such as the policies relating to the use of force and communicable disease) and should be cross-referenced. For example, an instance in which staff uses force requires the filing of an incident report and a communicable disease exposure incident would require an incident report. The policies and procedures should address the need to report any suspected child abuse and other mandated reports.

There are differences between an incident report (which is an internal written description of occurrences, disciplinary reports) and crime reports. Frequently, discipline and crime reports rely on an incident report to establish what occurred. Not all incident reports result in criminal prosecution or disciplinary actions. It is important to establish a filing system that differentiates between incident reports, disciplinary reports and crime reports. It is unnecessary to duplicate the information on two different forms. When a report may be used for more than one purpose, be sure to cross-reference them to facilitate retrieval of either one or both.

There are a number of different methods of filing and retaining incident reports. Some facilities retain them in the minors' booking jackets; others place them in a facility central incident file. Some use multiple copy forms with copies going to the booking jacket, the central file and to the staff person involved in the occurrence. Where reports are kept is less important than that they be kept. The long-term benefits of documentation cannot be realized unless the information can be retrieved and used when it is needed.